

and a build-up of primitive cells in the submucosa. The final result is ulceration of the entire intestinal tract including the colon. I do not think other antimetabolites have been much studied along these lines.

Professor HARRISON: This case would in fact be unique in world history if it were so; it would have produced a carcinoma in a human being in under two months!

Professor McMICHAEL: Well, I am glad to have that possibility excluded. We do not like to see damage from our therapeutic efforts.

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THE "MISSING" PATIENT

A SURVEY* OF 210 INSTANCES OF ABSCONDING IN A MENTAL HOSPITAL

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The adoption of the "open-door" system in mental hospitals, together with the legislation of the Mental Health Act, 1959, heralds a new era in the acceptance and treatment of the mentally disordered patient in society. The days of locked wards and padded rooms are over, and the maximum security that used to be almost the sole protection that society had from the disturbed patient has been largely replaced by active medical treatment and a permissive hospital environment. To enable the mental patient to be accepted and tolerated by society, it becomes essential that his restlessness be kept within the bounds of the hospital until it is considered desirable that such restriction be relaxed. Just as essential are the need for treatment and the co-operation of the patient in staying in hospital for this purpose. "Society acceptance" is placed first deliberately, since it is only by the co-operation of society that the restrictions that mean so much to mental patients can be lifted and thus help be given towards recovery and rehabilitation.

It therefore becomes important to discover the circumstances in which patients leave hospital without permission (defined in the *Oxford English Dictionary* as absconding), in the hope that when such circumstances are analysed, and reasons found, they can be corrected or avoided in the future and thus help to keep the patient in hospital until discharge is medically desirable. This problem is aggravated to-day by the smaller numbers of trained nursing staff; by the admis-

sion of patients who are psychopathic; by the vast majority of admissions that are informal—apprehension, if necessary, being possible by persuasion rather than coercion; and by a public that is only gradually being persuaded that mental illness should be treated like any other. This change of attitude is not helped by patients who elude their nurses, and annoy, frighten, or even harm the public. Therefore the wandering patient must, if possible, be controlled, since the "open-door" hospital has come to stay and staffing problems will not become any easier. Undoubtedly the opening of mental hospital wards helps in reducing restlessness, tension symptoms, and anxiety (Folkard, 1960), and the result is one of general benefit, although the absconding problem is important.

Method

There are 1,000 patients (585 female and 415 male) at any time at Powick Hospital, and notifications of unauthorized absence are made as soon as discovered: the term "unauthorized absence" is taken to mean leaving the hospital grounds without permission. In this survey notifications of such absences were made to me, and I interviewed the patient on his return and had access to all case papers and treatment details.

In addition, any other persons, members of the hospital staff included, who could contribute further information about why a patient absconded were seen, and in this way a comprehensive environmental assessment was made of each case. The conclusion drawn naturally depended upon my interpretation of the information, and this method is liable to personal bias. However, when suspected factors were corrected the number of missing patients was reduced, showing that some at least of the conclusions were correct.

This investigation produced a mass of detail from which only what was thought to be significant or interesting is set down here.

General Information

Over a nine-months period 98 patients were surveyed; some of them had been missing more than once, giving a total of 210 separate instances of absconding. The age distribution was uniform from 15 to 80 years; the male:female ratio was 3 to 2; 80% of the patients were of informal status; and 70% were single. There was no significant relationship between length of stay and frequency of absconding, but a greater tendency to this behaviour was found in cases of shorter stay. One absconder attempted suicide unsuccessfully and one threatened by telephone to do so but was apprehended first.

The diagnostic categories of the 98 absconding patients, together with the total number of patients in hospital at the time with such diagnoses, are shown in the Table.

	Percentage of Total Absconders	Percentage in Total Hospital Population
Schizophrenia (all types) ..	52	41
Manic-depressive psychosis ..	2	2
Dementia—senile	5	20
Paranoid psychosis	8	3
Epilepsy	1	4
Subnormal intelligence ..	8	5
Depression (all types) ..	6	13
Psychopathic personality ..	11	1.5
Alcoholic addiction	4	1.5
Miscellaneous	3	9

*This survey was carried out at Powick Hospital, Worcester.

It will be seen that the categories most likely to abscond are psychopathic personalities, alcoholic addicts, and paranoid psychotics; those least likely to abscond are senile demented and depressive cases.

It would therefore be possible to give an estimate of the number absconding in any hospital population if the number in each category is known.

A few persistent absconders left on no fewer than seven separate occasions, but 50% left once only. The duration of absence varied widely; 75% were absent for less than 24 hours, but periods up to 31 days were recorded. The highest incidence was in the winter months and from the wards for acute cases.

The police were notified in 50% of instances. Notifications were also made to the children's department of the local authority and to the probation officers where appropriate.

A total of 25% of the absconders did not return and were discharged.

Results

On analysing these cases it was found that there was generally one main reason for a patient absconding. Other reasons were often discovered, but on most occasions these were subsidiary; in some, however, they appeared to be of equal importance. A so-called subsidiary reason in one case could act as the main reason in another, and the list of reasons turned out to be a surprisingly small one. The frequency distribution was as follows: treatment failure 50%, family trouble 17%, alcohol 12%, "influence" 8%, and money 4%; leaving a residuum of 8% for which no reason could be found.

Discussion

Treatment Failure

Failure of treatment was by far the commonest cause, accounting for half of the cases. By treatment is meant physical methods, nursing care, interpersonal relationships, and the overall hospital environment. Of these patients, 66% were schizophrenic, thus reflecting the delusions, hallucinations, and restlessness that are so difficult to control in this disease. Patients often stated that a voice made them leave hospital, or that they felt that they should be elsewhere, and the resultant restlessness gave the necessary impetus and persistence to carry out delusional ideas. Treatment failure could be further broken down into three categories: (1) ineffective physical treatment in 40%, (2) lack of any physical treatment in 30%, and (3) a failure of interpersonal relationships in 30%—that is, treatment in the widest sense.

The first group was linked with the preponderance of schizophrenic patients, since it was found that treatment had been ineffective in controlling the symptoms mentioned previously. Tranquillizers had been prescribed in low dosage—for example, chlorpromazine hydrochloride ("largactil") 25 or 50 mg. t.d.s. in very restless patients; others were due for more electric-convulsion therapy (E.C.T.); and in yet others a change to a more powerful drug—for example, methotrimeprazine ("veractil")—would seem to have been desirable. This was especially so in patients prescribed paraldehyde or barbiturates only. This is not to suggest that all psychotic symptoms can be controlled, but that vigorous attempts should be made to do so either by pushing a preparation to the limits of tolerance or by substituting others. In this connexion it was found that E.C.T. and/

or methotrimeprazine were most effective in reducing the motor restlessness and some delusional ideation, whereas thioridazine hydrochloride ("melleril"), although not as powerful in reducing the motor component, was very effective in its psycholytic action. Trifluoperazine dihydrochloride ("stelazine"), "haloperidol," and "delysid" had the effect of agitating and confusing some patients, with the result that it was felt that six patients absconded because they had been prescribed one or other of these drugs. This is similar to the akathisia reported by Hodge (1959).

Of the patients under investigation, 30% were not given any drug at all in spite of nursing reports about their restlessness, impulsiveness, hallucinations, and delusions. The remedy here would seem to be straightforward.

The residual 30% of reasons in this group showed a failure of interpersonal relationships within the ward, or in the hospital as a whole. The confidence of these patients had not been obtained. Some were afraid of E.C.T.; some were transferred, without explanation, to other wards. One was deaf and unaware of the existing situation, others were made restive by a change in nursing staff, and patients who could not speak the language were more liable to abscond. Injudicious parole may put too much temptation in the way of the immature personality. This has been reported before by Shapiro, Cohen, and Budgen (1959). Also staff should be certain that a patient is orientated in a large hospital before parole is given for the first time.

It may seem a little critical to attribute these latter facts to treatment failure, but it is a failure to deal with the whole problem that the patient presents.

Family Trouble

In 17% family "trouble" was the reason for leaving hospital. More specifically this was contributed to by relatives who did not visit as promised, wives who gave cause for suspicion, parents who rejected their children, and relatives who were ill, in hospital, or dying. As expected, the minority of these patients were schizophrenic, and many were young.

This sort of problem can be prevented first by an awareness of the situation, and then a discussion with the family concerned by the sister in charge, doctor, or social worker. It may mean requesting relatives to appear for interview, or visiting the home; and often the problem may be tedious and frustrating. The result, however, was in most cases good, especially if other factors, such as efficient treatment, were attended to. More often than not the authorities were unaware that such a situation had arisen. It is also not always realized that relatives who visit may upset patients so much that they abscond later. What is said at these visits is generally unknown; one patient in this series was told by her husband that she was "round the bend" and would be here for the rest of her life. It was not surprising that she promptly absconded and made for the river. Visitors may also either actively encourage absconding or provide the means for doing so—for example, money.

Alcohol

It was considered that allowing a patient alcohol gave rise to absconding in 12% of cases. Some (one-third) were "alcoholics" who could not apparently do without a boost. In others it may have produced enough "Dutch courage" to overcome their timidity or sufficient

impulsiveness to leave. Alcohol was a subsidiary reason in many other cases where it potentiated and triggered off an already undecided patient. The giving of parole to some meant that they could then obtain alcohol and in this way leave hospital, and others who were given money could buy it. Thus it could mean that those patients who were given parole and money, possibly for the first time for years—following the open-door policy, recategorization, and money issue under the new 1959 Act—were faced with an irresistible temptation. It would be difficult to make a case here for alcohol being the primary reason, but it certainly is one reason.

It appears, then, that patients should not be allowed alcohol unless specifically permitted.

"Influence"

Influence accounted for 8% of missing patients, and it was quite apparent that the person with an influential restless personality had a very disturbing effect on others. Nursing staff were quick to spot such a patient, who required firm handling as well as a definite occupational programme. Boredom plays a big part in both the influencer and the influenced; this agrees with the work of Jones and Goodson (1959). The majority of patients were of psychopathic personality and removal of such a person to another ward had a good effect. Moreover, in one case the patient was discharged, since it was felt that the hospital had not the necessary facilities to deal with her. She persistently led other girls astray, and as soon as she was discharged the others became more stable. Insufficiently sedated or tranquillized patients were often easily influenced by the restless, and these cases responded to increased doses of drugs.

Money

Possession of money caused 4% of the patients to go missing, and in all cases it was found that they were getting money for the first time for many years. This, together with the freedom enjoyed under the new regulations, provided the key. This factor may work closely with factors mentioned previously in the paragraph on alcohol, and it was difficult to determine who was a "security risk" under these conditions. Undoubtedly, however, the possession of cash is a potent subsidiary factor in many cases. A combination of money, parole, and alcohol was often an unsettling mixture.

Lessons Learned

The application of the measures mentioned for the reduction of the missing-patient problem had most satisfactory results and the rate at which patients absconded decreased as a result of the lessons learned in individual cases. The measures which were helpful in reducing the number of absconding patients were potentiated by frequent ward and staff meetings held together or separately, and by close liaison with the social workers and mental welfare officers. Over the ensuing period there was a 50% reduction in the number of missing patients.

There will, however, always be a residuum of the unsuitable, unpredictable, and restless, and it is my impression that there is still a place for a closed ward for patients who are refractory to any prophylactic measure and for whom maximum security is desirable. A ward of this sort develops its own degree of tension, leading to increased restlessness, which has been pre-

viously reported by Somers (1959) and Folkard (1960), and although such a closed ward may be a necessary psychiatric "evil," it is better than a series of locked side-rooms. The beneficial effect of opening the "closed" ward was demonstrated in this hospital when the disturbed male admission ward had the locks removed for the first time. Contrary to prediction by the pessimistic, patients were not so restless, while general ward and hospital intercommunication increased, with the result that the absconding rate fell. This is the "Somers" effect in reverse.

Conclusions

It is felt most strongly that, judging by the results of this investigation, at least 50% of abscondings could be prevented by assessing behaviour carefully and frequently, by giving suitable drugs, by avoiding temptation in the form of alcohol and money, by the provision of family visiting and the disentangling of home problems, by the careful supervision of influential patients, and by an overall attention to interpersonal relationships. The realization of the importance of logical continuity in treatment, the maintenance of a stable staff personality and structure, and the elimination of capricious and contradictory measures will go far to eradicate the residuum. The influence of only one patient, refractory to hospital regulations, on an otherwise stable ward is not only harmful to the other inhabitants, but it undermines the tolerance of society in general.

Summary

An investigation into 98 patients who left hospital on a total of 210 occasions without permission revealed common reasons. These are analysed in detail and shown to be preventable in 50% of cases.

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Nova et Vetera

THE FIRST ENGLISH ANATOMIST

Never have the facts about the study of anatomy and the character of the available anatomical books in sixteenth-century England been presented so lucidly, so briefly, and yet so accurately as they are in a small book just published by the Oxford University Press.* It is the work of a professional medical historian (who is also a classical scholar) in Los Angeles and his collaborator, a professional anatomist (who is also a medical historian) in Melbourne. Between them they have—in a thirty-page introduction to an unknown text—clearly traced the origins of anatomical study in England and presented to us for the first time a hitherto unknown English anatomist who was responsible not only for the first dissection made in England (in 1531)

**David Edwardes—Introduction to Anatomy, 1532.* By C. D. O'Malley and K. F. Russell. (Pp. 64. 15s.) London: Oxford University Press. 1961.